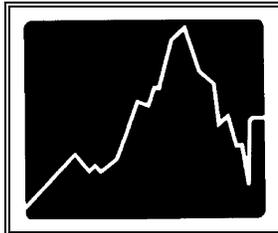


VIRGINIA BOARD OF SOCIAL WORK



Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
(804) 367-4441

Website - <http://www.dhp.virginia.gov/social>

REGISTRATION OF SUPERVISION FOR REACTIVATION OR REINSTATEMENT

Application and Supporting Documentation:

Upon completion of the **Registration of Supervision Application for Reactivation or Reinstatement** (this form should be completed by the applicant and the proposed supervisor) you will be required to submit to the Board office the following item in a single packet:

Fee: A \$50.00 registration fee paid by check or money order made payable to the “Treasurer of Virginia”. This fee is non-refundable and non-transferable.

Supervisor’s Certificate of Training: A copy of the proposed supervisor’s certificate of completion of professional training in supervision, consisting of a three credit-hour graduate course or at least 14 hours of continuing education offered by a provider approved under Regulation 18VAC140-20-105 is required. (Note: The graduate course or hours of continuing education in supervision shall be obtained by a supervisor within five years immediately preceding registration of supervision.)

Name Change: Documentation must be provided if your name has legally changed through marriage, divorce, or a court order. A photocopy of your marriage license or a copy of the court order must be provided.

The supervision experience must be substantially equivalent to those outlined in 18VAC140-20-50 and 18VAC140-20-60.

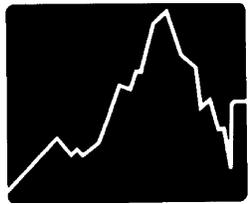
At the end of your supervision experience, please submit the Verification of Supervision for Reactivation/Reinstatement form attached below which must be completed by your supervisor.

When changing or adding supervisors, worksite or locations, an additional registration of supervision form must be completed and submitted to the Board along with an additional \$25.00 registration fee.

****PLEASE USE BLUE OR BLACK INK AND WRITE LEGIBLY.****

*Please make a copy of the completed form for your records
and send the original form to the board office for processing.*

**COMMONWEALTH OF VIRGINIA
BOARD OF SOCIAL WORK**

	<p>Department of Health Professions 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463 (804) 367-4441</p> <p>Website - http://www.dhp.virginia.gov/social</p>
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REGISTRATION OF SUPERVISION FOR REACTIVATION OR REINSTATEMENT

TO BE COMPLETED BY LCSW SUPERVISEE (Please type or print in black ink):

Initial Application		Add Work Site/Supervisor		Change Work Site/Duties/Supervisor	
Name (Last)	(First)	(Middle Initial)	(Maiden)		
Social Security Number or Virginia DMV Control Number*			Date of Birth (MM/DD/YY)		
Mailing Address (Street and/or Box Number, City, State, Zip Code)			Telephone Number Home: Alternate:		
Email address:					
Are you the spouse of a member of the U. S. military who has been transferred to Virginia and did you leave employment to accompany your spouse to Virginia? Yes No					
Name of proposed supervision work site where applicant will receive hours towards licensure (<u>ONE LOCATION ONLY</u>)					
Physical Address of proposed supervision work site where applicant will receive hours towards licensure (Street, City, State, Zip Code)					
1. Have you ever been denied the privilege of taking an occupational licensure or certification examination? If yes, state what type of occupational examination and where:				Yes	No
2. Have you ever had any disciplinary action taken against an occupational license to practice or are any such actions pending? If yes, explain in detail.				Yes	No
3. Have you ever been convicted of a violation of or pled nolo contendere to any federal, state, or local statute, regulation or ordinance or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations and driving under the influence.) If yes, explain in detail and provide court documents.				Yes	No
4. In the last twelve (12) months, have you been unable to practice social work by reason of excessive use of alcohol, drugs, chemicals or any other type of material or as a result of any mental or physical condition? If yes, please provide an explanation on a separate sheet of paper.				Yes	No
5. Have you ever been censored, warned, or requested to withdraw from your employment, terminated from any health care facility, agency, or practice? If yes, provide an explanation on a separate sheet of paper.				Yes	No

TO BE COMPLETED BY SUPERVISOR (Please type or print legibly in blue or black ink):

Supervisor's Name (Last, First)	Supervisor's Business Name and Address
Supervisor's Email Address	Supervisor's Telephone Number
Type of Professional License	Virginia License Number
Initial License Date	Licensure Expiration Date

If your answer is "No" to any of the following questions, please provide an explanation on a separate sheet of paper which must be signed and dated by the supervisor and supervisee.

1. Does the supervisor meet the requirements of 18 VAC 140-20-50(B)?	Yes	No
2. If applying for LCSW Reactivation, will the supervisee average no less than 15 hours per 40 hours of work experience in face-to-face client contact?	Yes	No N/A
3. If applying for LSW Reactivation, will the supervisee provide "casework management and supportive services" as outlined in the Regulations Governing the Practice of Social Work and Code of Virginia Chapter 37 of Title 54.1?	Yes	No N/A
4. If applying for LCSW Reactivation, will the supervisee provide "clinical social work services" as outlined in the Regulations Governing the Practice of Social Work and Code of Virginia Chapter 37 of Title 54.1?	Yes	No N/A

DECLARATION OF SUPERVISOR AND SUPERVISEE

We, _____ (name of supervisor), and _____ (name of supervisee) hereby certify that:

We have read, understand and will comply with the Laws and Regulations Governing the Practice of Social Work and hereby agree to this supervision which is being registered with the Virginia Board of Social Work.

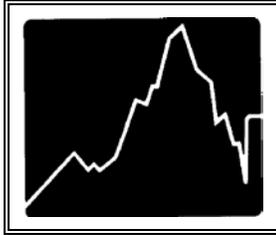
SIGNATURE OF SUPERVISOR

DATE

SIGNATURE OF SUPERVISEE

DATE

COMMONWEALTH OF VIRGINIA
BOARD OF SOCIAL WORK



Department of Health Professions
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VERIFICATION OF SUPERVISION FOR REACTIVATION OR REINSTATEMENT

This form is to be completed at the **end** of the supervised experience

I. GENERAL INFORMATION	PLEASE TYPE OR PRINT CLEARLY	USE BLUE OR BLACK INK
Name of Applicant (Last, First)	Applicants Email Address	
II. SUPERVISOR'S EVALUATION:		
Supervisor's Name (Last, First)	Supervisor's Telephone Number	
Business Name and Address of Supervision Work Site (ONE LOCATION ONLY)		
Dates of supervision: From: _____ to _____ = Total Number of Weeks: _____		
Did the applicant receive a minimum of one (1) hour and a maximum of four (4) hours of face-to-face supervision per 40 hours of work experience while under your direct supervision?	Yes	No If not, explain on separate page
If applying for LSW Reactivation/Reinstatement , did the applicant receive a minimum of 360 hours of supervised experience in casework management and supportive services supervision?	Yes	No N/A If not, how many? _____
If applying for LSW Reactivation/Reinstatement , did the supervisee provide "casework management and supportive services" as outlined in the Regulations Governing the Practice of Social Work and Code of Virginia Chapter 37 of Title 54.1?	Yes	No N/A
If applying for LCSW Reactivation/Reinstatement , did the applicant receive a minimum of 360 hours of supervised experience in clinical social work services supervision?	Yes	No N/A If not, how many? _____
If applying for LCSW Reactivation/Reinstatement , did the supervisee provide "clinical social work services" as outlined in the Regulations Governing the Practice of Social Work and Code of Virginia Chapter 37 of Title 54.1?	Yes	No N/A
In your opinion has the applicant demonstrated competency sufficient for reactivation or reinstatement?	Yes	No N/A If not, explain on separate page
I declare that, to the best of my knowledge, the foregoing is true and correct.		
_____	_____	
Supervisor's Signature	Date	